

BULLETIN

EDITORIAL PG 10

Nuts and Bolts of Telemedicine in Indiana

by STEPHANIE T. ECKERLE AND STACY WALTON LONG
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OFFICIAL MONTHLY PUBLICATION OF THE

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BULLETIN SUBSCRIPTIONS: \$36.00 per year

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LETTER FROM THE EDITOR:

Thank you for your readership! The Bulletin is your magazine. If you have an idea or opinion you'd like to share, or an article you have written, please email me at mperrill@indymedicalsociety.org. We would love to publish it.

We want to hear from you if you want to get involved or have a great idea! Please reach out at any time if you want to get more involved. I would love to hear from you or meet you in person!

Sincerely,

Morgan Perrill
Executive Vice President



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THE PRESIDENT'S PAGE

CHRISTOPHER D. BOJRAB, MD

At a time in which membership in professional societies is on the decline, we often ask why people join and maintain their memberships in these organizations. In fact, we started our board meeting in July by going around the room and having each member answer this very question. Many physicians responded by saying that they felt it was an important part of advocacy work on behalf of our patients, an important way to support our fellow physicians, a way to enjoy the collegiality of our peers, as well as a variety of similar sentiments. Another common theme that was discussed was the idea that membership in one's professional organizations was simply the right thing to do and was an important part of being a professional.

I have to admit that this was my response as well. I recall being in medical school and being a member of the medical student section of the American Medical Association as well as the Indiana State Medical Association. My involvement continued during the course of my residency and I later served as the president of the young physician section of the Indiana State Medical Association. My interest in being a member of these organizations was certainly not because of any specific tangible benefit, of which there were relatively few as a medical student or resident. Rather, my interest in participation was born out of the fact that my teachers and mentors during the course of my medical education were members of and actively involved in their professional societies.

Membership in our professional societies affords us the opportunity to come together as physicians to advocate for our patients, ourselves, and our profession. This seems to me to be especially important at a time in which there are so many forces pulling us apart including increasing administrative burdens, increasing demands on our time and energy, decreasing resources, increasing costs, as well as the never ending challenge of providing expert medical care to our patients.



Your Indianapolis medical society has been reviewing both internal and external data sources in order to better understand factors influencing our colleagues' decision to either join or not join professional medical organizations. We are also reviewing our mission statement and vision statement in an effort to bring those into alignment with the current priorities and strategies of the organization.

If you have not recently done so, I would recommend visiting our newly revised website at indymedicalsociety.org. There you can access a membership directory containing the contact information for many of our colleagues including office addresses, email, websites, fax and phone numbers - think of it as the digital equivalent of the old "Pictorial Roster" (aka "The Funny Book"). It is a great source of information regarding a variety of medically related activities and events throughout the area. You can also find links there for the Indianapolis Medical Society's presence on Facebook, Twitter, Instagram, and Linked In. We would welcome your feedback on our new website, social media outreach, as well as the redesign of The Bulletin.

As a reminder, please mark your calendars for the 170th Annual Convention of the Indiana State Medical Association September 13-15 at its new location in the Embassy Suites Noblesville Conference Center. All ISMA members are welcome to attend.

Chris Bojrab MD

Chris Bojrab, MD
President, Indianapolis Medical Society

Single Payer Post Election

by RICHARD D. FELDMAN, MD

IMS Board Member, Family Physician, Former Indiana State Health Commissioner



The balance of power is now divided between a Democratic House and a more conservative Republican Senate. Obamacare will likely continue for now in limbo, maimed but not dead. Obamacare's flaws were left to languish by a Congress determined to see its demise. Even worse, Congress repealed vital portions, including the individual mandate that disrupted the basis of its functionality. But it was a bold first attempt to expand health insurance to millions of Americans who desperately needed coverage. Obamacare is far from "socialized medicine" and is based on principles other countries have utilized to create successful universal high quality and lower-cost multi-payer systems. But our toxic political atmosphere would not allow fixing Obamacare's flaws to make it truly functional and equitable.

So, what's next in health-care reform? Medicare for All, a single-payer government system? More of the failed Republican approach of free-market principles, Health Savings Accounts, and consumerism? Health care does not follow the usual rules of economics. A Republican model would result in greatly contracted coverage. If combined with popular elements of Obamacare (like coverage for pre-existing conditions), which were never designed to be selectively utilized in isolation, it would result in unsustainable higher costs.

The American public is not yet ready for Medicare for All, presently promoted by the left hand of the Democratic Party. But if the next compromised paradigm fails, ironically, a single-payer system may be the only option left for a health-care system left in shambles. America is the only highly developed country in the world that does not guarantee health-care coverage for all people. The public will demand a different and more humane approach.

The Americans are increasingly warming to the idea of single-payer. Although the results of surveys vary, a Kaiser Family Foundation poll found that 53 percent of the public now favors single-payer (43 percent opposed).

"a Kaiser Family Foundation poll found that 53% of the public now favors a single-payer. The favorable response increases to 64% when termed "Medicare for All"."

The favorable response increases to 64 percent when termed "Medicare for All". Not surprisingly, a majority of Democrats and independents are in favor, while 67 percent of Republicans are opposed.

Physicians are increasingly positive regarding single payer. Another Kaiser survey revealed that 56 percent of physicians are supportive. Doctors are tired of system-complexity and bureaucratic and paperwork nightmares, and increasingly believe in the goal of universal coverage.

The most prominent single-payer plan belongs to Sen. Bernie Sanders. His Medicare for All plan is gaining significant support with Senate Democrats, unthinkable as a mainstream idea just a few years ago.

His plan eliminates Medicaid and almost all private and employer-sponsored insurance, insuring comprehensive care to all people. It is considerably more generous than Medicare presently with no premiums, co-pays or deductibles, and covers virtually the entire continuum of medical care including vision and dental. It

includes negotiated lower-cost prescriptions and long-term care. Patients have free choice of providers and navigate a much less complex health-care system.

However, the plan is enormously expensive, paid for mostly by tax increases to employers and individuals, which according to the Kaiser poll, greatly erodes public support even though offset by virtually no out-of-pocket costs. That might be different in the future if there is no viable alternative. A less generous plan, or a government plan as an alternative choice would be more financially and politically feasible.

The federal government now pays for two-thirds of health costs; it wouldn't be a stretch to 100 percent. My Medicare patients are actually quite content. Sanders' plan is an introduction to the American public of what the future may hold.



Gateway to Work: Healthy Indiana Plan

by STEPHEN DOWNING
Manager, Community Relations MHS



Gateway to Work Program Helps HIP Members Connect with New Opportunities

Community engagement programs have been in the news lately. What's the latest on Indiana's community engagement program, and how will it impact members? Stephen Downing, Manager of Community Relations at Managed Health Services (MHS), explains.

What is Gateway to Work?

You are probably familiar with the Healthy Indiana Plan (HIP) - it's Indiana's Medicaid expansion program that provides health coverage to adults ages 19 to 64 who meet specific income levels. Gateway to Work is a new part of HIP that helps connect members with job training, education or assistance finding the right job or volunteer activity.

Starting this month, qualifying HIP members are required to work, go to school, volunteer or participate in other qualifying activities for 20 hours per month. The number of hours required increases gradually over the coming year, with members required to report 80 hours a month starting in July 2020.

Who is eligible for Gateway to Work?

Many HIP members are already exempt from the Gateway to Work requirements. For example, members who are already employed at least 20 hours per week, full- and half-time students, or those who serve as a primary caregiver for a young child won't be required to participate. Members who are medically frail, pregnant, over the age of 60, or receiving TANF/SNAP benefits are also exempt, among other exceptions.

How can members meet the requirements?

There are countless ways a member can complete their required hours, including:

- Employment – full or part-time jobs, job search activities or on-the-job training

- Education – high school equivalency or adult education programs, job skills training, vocational education, or literacy or English as a Second Language (ESL) classes

- Community Engagement – public service, volunteer work, or community work experience

- Other – care-giving services, homeschooling, or other activities based on review

How is MHS helping members connect with Gateway to Work opportunities?

As one of four managed care entities (MCEs) in the state that provides coverage to HIP members, MHS has been preparing for this program for more than two years. Our goal is to ensure that every single one of our HIP members understands

the program requirements and is able to connect with resources needed to participate in the program. We have created a dedicated Gateway to Work team made up of social workers and case managers who are ready to assist members find the opportunities that are the

best fit for their situation.

We've even installed a dedicated Member Connect station in our downtown office lobby, where members can stop by, use an iPad to log their hours, and chat with our Gateway to Work specialists in person. We'll have iPads at select community events as well to assist members who may not have internet access at home.

Many times our members are facing complex barriers – health-related and otherwise – that prevent them from fully participating in the workforce. Our goal is to work closely with members to address and remove those barriers and develop a plan for success.

How are community partners involved?

MHS has developed unique partnerships with trusted community partners across the state who are already doing incredible work with our members. For example, Indy Reads offers adult literacy and ESL classes and does an



SPECIAL FEATURE *CONTINUED*

amazing job – MHS provides free Lyft transportation to classes for our members, plus rewards for achieving literacy goals.

We've partnered with the Department of Workforce Development (DWD) to offer free high school equivalency prep courses and waive the test fee for any member who wants to get their HSE diploma. Not only do the hours spent preparing and taking the test count toward Gateway to Work, the member will be better positioned to move forward in the workplace with a diploma in hand.

We have additional partnerships with Ivy Tech and more to give our members a wide variety of options, and will continue to build relationships as the program grows.

How can healthcare providers help?

Helping our members succeed in the new Gateway to Work program will undoubtedly be a team effort. As a healthcare provider, you are a trusted source of information. You can help by talking to your HIP members

about Gateway to Work. Do they know about the program? Do they know their reporting status? Do they have any concerns? Let members know they can contact their MCE for assistance. Our Gateway to Work team is standing by and excited to help our members make the most of this opportunity.

You can learn more about Gateway to Work at in.gov/fssa/gateway or mhsindiana.com/gateway-to-work, or contact our team at 1-833-245-7901. Thank you for all that you do to care for our members!



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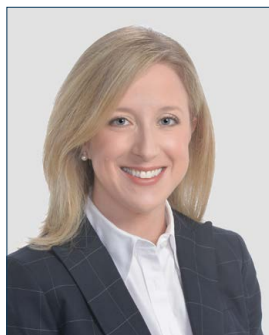
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Nuts and Bolts of Telemedicine in Indiana



by STEPHANIE T. ECKERLE AND
STACY WALTON LONG
Krieg DeVault LLP

Healthcare providers regularly engage in the practice of telemedicine, both within Indiana and elsewhere. Although the practice of telemedicine has existed for many years, the statutory and regulatory requirements, technology, and best practices are constantly evolving. Providers should be aware of the key provisions of Indiana law governing telemedicine services.

Establishing the Provider-Patient Relationship via Telemedicine:

It is critical that providers understand the proper manner in which a provider-patient relationship should be established pursuant to Indiana's telemedicine statute. This is especially critical since a provider-patient relationship must be established prior to issuing a prescription. Indiana law specifically requires prescribers to take the following steps to establish that relationship: (1) Obtaining the patient's name, contact information and location; (2) Disclosing the prescriber's name and status; (3) Obtaining the informed consent of the patient; (4) Obtaining the medical history and information necessary to establish a diagnosis; (5) Discussing with the patient the diagnosis, evidence for diagnosis and risk/benefits; (6) Creating a medical record for the patient; (7) Coordinating with the primary care physician if the patient consents; (8) Providing instructions for follow-up care; and, (9) Providing a telemedicine visit summary to the patient, including information about prescriptions. Although the provider can prescribe legend drugs to the patient once the provider-patient relationship is established, the provider must ensure that the same standard of care is met as if the provider was providing in-person services and the prescription is within the prescriber's scope of prac-

tice and applicable certifications.

Prescribing Controlled Substances via Telemedicine:

Prescribing a controlled substance via telemedicine is restricted under both state and federal law. Under Indiana law, a prescriber cannot prescribe opioids via telemedicine unless such are being used to treat opioid dependence. Furthermore, a prescriber can only prescribe controlled substances via telemedicine if the following conditions are met: (1) the prescriber maintains an Indiana Controlled Substance Registration (CSR), (2) the prescriber meets the requirements of certain federal laws, (3) the patient has been examined by a licensed Indiana health care provider who has established a treatment plan to assist in the diagnosis of the patient, (4) the prescriber has reviewed and approved the treatment plan and is prescribing pursuant to that treatment plan, and (5) the prescriber complies with the requirements of INSPECT.

All prescribers practicing telemedicine must also ensure compliance with the Ryan Haight Act, which amended the Controlled Substance Act in 2009. The Ryan Haight Act requires that prior to prescribing a controlled substance, a provider must either conduct at least one in-person medical evaluation or must meet the definition of a "covering practitioner," unless the practitioner is engaging in the "practice of telemedicine." The definition of telemedicine in the Controlled Substance Act is narrow and includes situations where (1) the patient is located in a hospital at the time of the telemedicine encounter; (2) the patient is being treated and in the physical presence of a practitioner during the telemedicine encounter;

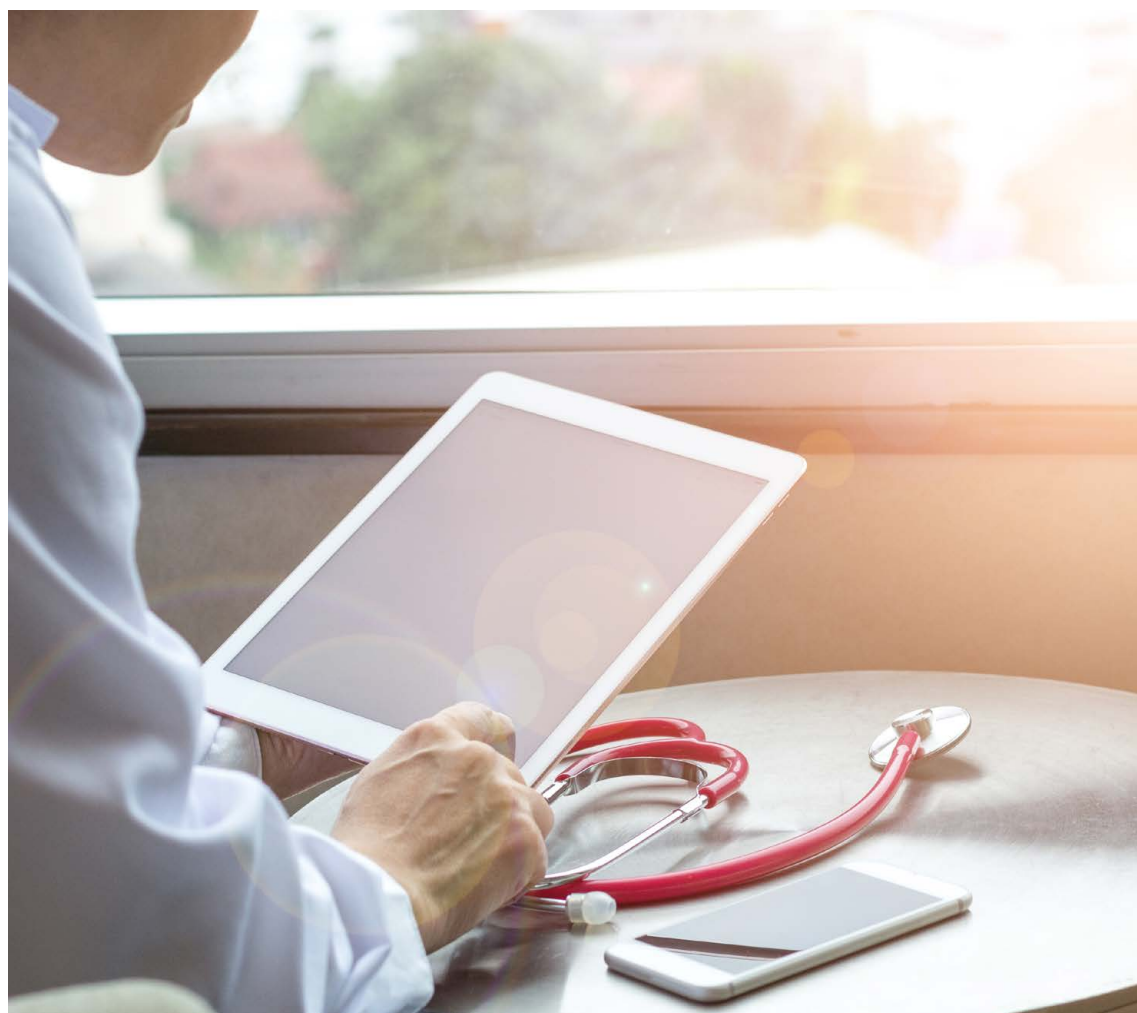




AUTHORS NOTE:

The contents of this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended only for general informational purposes only, and you are urged to consult your own attorney concerning your situation and specific legal questions you have.

If you have specific questions regarding telemedicine or other healthcare issues, please contact Stephanie Eckerle (317) 238-6373 (seckerle@kdlegal.com) or Stacy Walton Long (317) 238-6356 (slong@kdlegal.com) at Krieg DeVault LLP.



(3) the practitioner is an employee or contractor of Indiana health services; or, (3) the telehealth encounter is done during a designated public health emergency.

Indiana Medicaid Reimbursement for Telemedicine:

If a provider intends to seek reimbursement from Medicare, Medicaid or private payors for telemedicine services, the provider should understand any specific requirements imposed by that third-party payor. For example, House Enrolled Act 1337 (HEA 1337) updated Indiana's Medicaid reimbursement requirements, which were effective June 27, 2018. HEA 1337 removed the 20-mile restriction on telemedicine services (which previously did not apply to federally qualified health centers, rural health centers, community mental health centers, and critical access hospitals). Further, under Indiana Medicaid, the patient must be at an originating site with an attendant to connect the patient to the provider at the distant site. The telemedicine services may be rendered in an outpatient, inpatient, or office setting. Lastly, certain services and providers will not be reimbursed for telemedicine by Indiana Medicaid, including but not limited to, ambulatory surgical centers, outpatient surgical services, chiropractic services and podiatric services.

Telemedicine Policies and Procedures:

Once physicians understand the legal framework they are operating under when providing telemedicine, the physicians or their employer should consider creating telemedicine policies and procedures. These policies should go beyond the regulatory necessities and address other operational and policy considerations. Considerations that may be relevant to policies and procedures are: (1) what type of telemedicine software and hardware will be utilized, (2) does the organization have emergency management protocols for telemedicine services, (3) does the organization have the proper privacy and security protections in place for telemedicine services and are they aligned with HIPAA policies and procedures, (4) does the telemedicine platform integrate with the EMR, (5) how is informed consent handled, especially with regards to minors, (6) are the providers intending to treat patients outside of Indiana and, if so, what is the associated legal framework, (7) what location will the patients and physicians be at when the telemedicine services are provided, and (8) who is the third party payor for the telemedicine services.

With the growth of telemedicine services, there will continue to be constantly evolving regulations, technology and best practices. It is important for physicians to not only consider how telemedicine impacts and potentially enhances patient care and access, but also what operational and legal requirements need to be put into place when providing telemedicine services. If you have specific questions regarding telemedicine or other healthcare issues, please contact Stephanie Eckerle (317) 238-6373 (seckerle@kdlegal.com) or Stacy Walton Long (317) 238-6356 (slong@kdlegal.com) at Krieg DeVault LLP.

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Medical Students Point to History in Pledging to Advocate for Safe, Legal Abortion

by JESSICA CHIANG AND AIDA HADDAD, MDIV
American Medical Women's Association advocacy task force members



The news as of late reflects the dystopian status of present-day healthcare. Numerous states have stripped away fundamental reproductive rights by criminalizing abortion with ruthless disregard for anyone capable of becoming pregnant. In April, our own Indiana Governor Eric Holcomb banned dilation and evacuation procedures—the most common method used during second-trimester abortion. The dilation and evacuation procedure is safe for the pregnant person, and banning it is simply a political move towards ensuring Indiana's status as an anti-choice state. States issuing such restrictions, which most endanger marginalized communities (including poor cis women of color, trans men, and non-binary people), seek to intimidate physicians who perform abortion procedures.

Recently, Alabama Governor Kay Ivey signed a near-total abortion ban (HB 314). This legislation in Alabama, in tandem with the 'heartbeat' bills signed in Iowa (SF 359), Kentucky (SB 9), and Ohio (SB 23) in the recent past, all serve as measures of making abortion illegal on the federal level. Gov. Ivey and Ohio Governor Mike DeWine signed their heartbeat bills in April, even after IA and KY's bills were struck down and temporarily blocked in federal court, respectively. Their signatures, accompanied by an anemic legal precedent at best, therefore serve to incite a series of legal battles ending at the Supreme Court level with the hope of overturning *Roe v. Wade*, according to the most recent statement made by the American Association for the History of Medicine. While *Roe v. Wade* has been regarded as immovable law for almost fifty years, the recent appointment of Brett Kavanaugh, whose own alleged history of sexual assault was brought to light during his

2018 hearing, places the ruling on shaky ground. The successful appointment of Kavanaugh not only put a person's right to speak out against unfit nominees to public office in question but also a person's right to comprehensive reproductive health care—namely, to abortion. On May 28, the current Court showed its sympathy for the anti-abortion cause by upholding the Indiana state law requiring burial or cremation of fetal remains after an abortion—again, potentially giving “conservative state legislatures confidence that restrictions may survive court challenges.”

“Abortion will not stop if made illegal. Instead, a pregnant person will be forced to turn to life-threatening alternatives ... outcomes that prompted the Supreme Court to confirm abortion as a constitutional right in 1973.”

While this and anticipated anti-abortion rulings will bolster what little legal precedent exists to rescind *Roe v. Wade*, abortion bans are an egregious misrepresentation of constituents' opinions on abortion-related healthcare. For example, ALG Research of Planned Parenthood (2018) found that 65% of Alabamians support abortion access in cases of rape, incest, or the endangerment of the pregnant person's life. There is

no state in the United States where more than 25% of its population supports a 6-week abortion ban. Americans do not want these bans. In fact, a select group of physicians initiated the anti-abortion movement in the mid-19th century, led by Horatio Storer, who is rather ironically often cited as the father of gynecology. The crusade against abortion occurred within an extreme, sexist context and was more than just a ploy to control women at the time. Professor Leslie J. Reagan of the University of Illinois writes in her 2019 *TIME* article that something more sinister could have been at work—an agenda to promote the birth of more middle-class white babies to effectively prevent overpopulation by “foreigners,” “freedpeople,”

and people of color. This type of segregative thinking may feel antiquated, but since the 2016 election of Mr. Trump, the United States has seen a resurgence of white supremacist ideation. Today, the modern crusade against abortion capitalizes on a health care system that disproportionately bars people of color, as a group, from good health. In this sense, it is no longer about increasing the number of white babies; rather, it is about actively burdening pregnant people of color with undue risk.

And so, abortion will not stop if made illegal. Instead, a pregnant person will be forced to turn to life-threatening alternatives resulting in sepsis, infertility, or death—outcomes that prompted the Supreme Court to confirm abortion as a constitutional right in 1973. According to Professor Reagan, “Before Roe, hospitals had entire wards for patients experiencing sepsis after shoddy or self-induced abortions.

Chicago’s Cook County Hospital had 5,000 patients annually in the abortion ward — women who were bleeding, infected and sometimes dying.” This reality is made increasingly poignant in Dr. Julie Inglefinger’s piece in the *New England Journal of Medicine* about ‘Jane’ (a pseudonym), a young nurse in New York from the Virgin Islands, who is one of the thousands of women that endured a back-alley abortion only to go into sepsis and ultimately kidney failure. From then on, Jane must undergo acute dialysis at a young age. Even with dialysis as a lifeline, Jane dies from acute bleeding with a hemothorax only months after her back-alley abortion.

Dr. Inglefinger closes stating, “Five years later, Jane would not have died — abortion had become legal in the United States. Over the ensuing decades, safe and legal abortion became standard. Thus, Jane would have, like me, become a grandmother, and would probably still be working and serving others.”

The tragic stories of botched abortions predominantly affecting marginalized communities are a chapter in history to which we cannot return. As future physicians, we pledge to advocate for safe, legal abortion and to support procedures informed by evidence-based medicine as outlined in the American College of Obstetricians and Gynecologists’ 2018 statement. We oppose any action to weaken or overturn the landmark case *Roe v. Wade* and urge our readers to join us in protecting reproductive choice, and therefore healthcare.

NOTE FROM THE EDITOR:

The following are the opinions of two of the ISMA Student members. This article is published with the intent to encourage discussion. If you have an opposing viewpoint, **please send it**. We would be happy to publish it in next month’s edition. Additionally, if you have an editorial you would like to share please feel free to submit it to me at mper-rill@indymedicalsociety.org.

1 Lange K. *ACLU sues Indiana over near-ban on most common second-trimester abortion procedure*. *The Indianapolis Star* [Internet]. 2019 [cited 4 June 2019];. Available from: <https://www.indystar.com/story/news/politics/2019/04/25/aclu-sues-indiana-over-law-banning-common-second-trimester-abortion-procedure/3573597002/>

2 American Association for the History of Medicine. *Heartbeat Bill Statement – AAHM Members* [Internet]. 2019. Available from: <https://docs.google.com/document/d/1R7qnCJukA2jBdMKr-M5nXWVr19LmrBITWojoOimjsJM/edit>

3 Davies T. *Indiana fetal remains law could boost costs for abortions*. *The Washington Post* [Internet]. 2019 [cited 4 June 2019];. Available from: https://www.washingtonpost.com/national/health-science/indiana-fetal-remains-law-could-boost-costs-for-abortion/2019/05/29/03a1aa64-825c-11e9-b585-e36b16a531aa_story.html?utm_term=.6d2011b4162d

4 Aron N. *The father of American gynecology fought to criminalize abortion in the 1850s* [Internet]. *Timeline*. 2019 [cited 5 June 2019]. Available from: <https://timeline.com/horatio-storer-criminal-abortion-c433606491da>

5 *We Don’t Have to Imagine the Consequences of Abortion Bans. We Just Have to Look to the Past*. *TIME Magazine* [Internet]. 2019 [cited 5 June 2019];. Available from: <https://time.com/5589993/alabama-abortion-law-history/>

6 *Ibid*.

7 Ingelfinger J. *A Remembrance of Life before Roe v. Wade*. *The New England Journal of Medicine* [Internet]. 2019 [cited 3 June 2019];379(8):708-709. Available from: <https://www.nejm-org.proxy.medlib.uits.iu.edu/doi/10.1056/NEJMp1809150>

8 *Ibid*.

9 American College of Obstetricians and Gynecologists (ACOG). *ACOG Opposes U.S. Senate Effort to Limit Abortion Access* [Internet]. 2018. Available from: <https://www.acog.org/About-ACOG/News-Room/Statements/2018/ACOG-Opposes-US-Senate-Effort-to-Limit-Abortion-Access?IsMobileSet=false>

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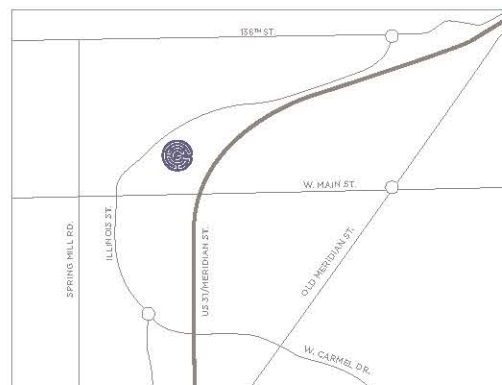
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GOODMAN CAMPBELL
BRAIN AND SPINE

THE BULLETIN BOARD

MATTHEW T. FENG, MD



Matthew T. Feng, MD, a corneal transplant, cataract, and LASIK surgeon at Price Vision Group, has received the American Academy of Ophthalmology Achievement Award. Dr. Feng is also co-medical director of the VisionFirst Indiana Lions Eye Bank. Last week at the Eye Bank Association of America annual meeting, he received the Richard Lindstrom Research Grant Award to study ocular applications of an intelligent pressure-sensing needle in collaboration with the Karp lab at Harvard's Brigham and Women's Hospital.

STEPHEN W. PERKINS, MD



Stephen W. Perkins, MD of Meridian Plastic Surgeons, was an invited faculty member at the recent 15th Vegas Cosmetic Surgery & Aesthetic Dermatology symposium in Las Vegas. Dr. Perkins presented lectures on the topics of rhinoplasty and facelift. He moderated a panel on the topic of facelifting and taught a master class on surgical lip rejuvenation.

RICK C. SASSO, MD



Rick C. Sasso MD, Indiana Spine Group, was the Course Director for the 12th Annual Cervical Spine Research Society's Hands-on cadaver course which was held May 30-June 1, 2019 in St. Louis, Missouri. Dr. Sasso assembled world-renowned cervical spine surgeon faculty from throughout North and South America to teach advanced surgical techniques to cervical spine surgeon participants who attended from throughout the world.

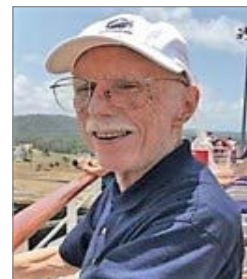
Rick C. Sasso MD, Indiana Spine Group, served as a faculty member at the 16th annual State of Spine Surgery Think Tank which was held in Aruba June 27-29, 2019. The "Long-term data on cervical disc replacement" is the lecture Dr. Sasso was invited to present.

Please submit Bulletin Board Information to ims@imsoline.org.
Your photo in the IMS files will be used unless an updated picture is submitted with your material.

IN MEMORIAM

JAMES MATTHEW DONAHUE, MD

James was born on April 20, 1934 in Carmel, IN. He attended Indiana University and graduated from IU Medical School. He was board certified in Psychiatry. When James graduated from college, he joined the United States Army for several years in San Juan, Puerto Rico. After he was done in the military, he had a private practice for many years. He was then in The United States Air Force and Air Force Reserves for 20 years where he attained the rank of Colonel. He was called upon for a brief time during Operation Desert Storm and served at Wright-Patterson Air Force Base. James was a Medical Director of Central State Hospital in Indianapolis where he did locum tenens work until his retirement. IMS Member since 1997.



CME & CONFERENCES

MONTHLY EVENTS

	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1st Week of the Month	Community North: Breast Cancer Conf. 7-8 am	Community East: CHE Admin Conf. 12-1 pm Community North: Psychiatry GR 12:30-1:30 pm Community North: Chest Cancer Conf. 7-8 am Community Heart & Vascular: Imaging Conf. 7-8 am		Community North: Forum 7-8 am Community South: South Case Presentations 12-1 pm
2nd Week of the Month	Community East: Medical GR 1-2 pm Community South: South General CHS 12-1 pm	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: M&M Conf. 7-8 am Community South: Breast Cancer Conf. 8-9 am St. Vincent Simulation Center: Pediatric GR 12-1 pm St. Vincent Womens: Neonatology GR 12-1 pm	St. Vincent: Echocardiography Conf. 7-8 am	Community North: Gynecological/Oncology Conf. 7-8 am
	Community North: Breast Cancer Conf. 7-8 am Community South: South Thoracic 8-9 am Community South: South Molecular 5-6 pm	Community North: Psychiatry GR 12:30-1:30 pm Community North: Melanoma 7:30-8:30 am Community Heart & Vascular: CV Conf. 7-8 am	St. Vincent Heart Center: Cardiac, Medical, Surgery 7-8 am	Community North: GU Conf. 7-8 am Community South: South Case Presentations 12-1 pm
	Community East: Breast Cancer Conf. 7-8 am	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: Disease Manage Conf. 7-8 am St. Vincent Womens: Perinatal Case 7-8 am	St. Vincent Womens: St. Vincent Simulation Center: St. Vincent Simulation Center:	MFM Ultra Sound Series Sim Debriefing Essentials PMCH Crisis Management
				Quarterly 1-4 pm 12x/Year 12x/Year

WEEKLY EVENTS

Day of the Week	Event
Monday	St. Vincent: General Cardiology 7-8 am
Tuesday	St. Vincent: Trauma Case 12-1 pm St. Vincent Womens: Neonatology Journal Club (every other month) 12-1 pm
Wednesday	St. Vincent: CCEP 7-8 am St. Vincent Heart Center: Interventional Cardiology 7-8 am St. Vincent: Advanced Heart Failure 7-8 am St. Vincent: Surgery Didactics 7:30-8:30 am St. Vincent: Surgery M&M 6:30-7:30 am
Thursday	St. Vincent PMCH: Pediatric Cardiothoracic Surgery & Cardiology Conf. 12-1 pm St. Vincent OrthoIndy: Fractures 8-9 am
Friday	

ONLINE EVENTS

Indiana University School of Medicine
 HPV Documentary, Someone You Love: The HPV Epidemic
<http://cme.medicine.iu.edu/hpvdocumentary>
 Opioid TeleECHO Clinic Providers and Prescribers Webinar
<https://iu.cloud-cme.com/opioidecho>

AUGUST EVENTS

August 23-24 INAAP Pediatric Conference, Fort Wayne, IN

SEPTEMBER EVENTS

Sept 6 Obesity Symposium Indianapolis, IN
 Sept 14 AMWA LIFT Training, Ivins, UT
 Sept 12-14 Midwestern Vascular Surgical 43rd Annual Meeting, Chicago, IL
 Sept 20 Diagnosis & Management of Foregut Motility, Indianapolis, IN
 Sept 27 Fairbanks Conference on Clinical Medical Ethics, Indianapolis, IN
 Sept 28 IU Health Glaucoma Symposium, Carmel, IN

For more detailed information, please visit the events page on our website at www.indymedicalsociety.org/imsevents

To submit articles, Bulletin Board items, CME & events, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.

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BOARD OF DIRECTORS 2019

Terms End with Year in Parentheses

Linda Feiwell Abels, Chair and Ramana S. Moorthy, Vice Chair

Rania Abbasi (2021)
Linda Feiwell Abels (2019)
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Ann C. Collins (2021)
Julie A. Daftari (2019)

Richard D. Feldman (2019)
Ann Marie Hake (2020)
Mark M. Hamilton (2021)
Tod C. Huntley (2019)
David A. Josephson (2020)

Chad R. Kauffman (2019)
Jeffrey J. Kellams (2021)
Stephen R. Klapper (2019)
John E. Krol (2020)
Ramana S. Moorthy (2020)

Thomas R. Mote (2019)
Mercy O. Obeime (2021)
Scott E. Phillips (2020)
Taha Z. Shipchandler (2020)
H. Jeffrey Whitaker (2020)

PAST PRESIDENTS' COUNCIL 2019

** Indicates Voting Board Members, Term Ends with Year in Parentheses*

Carolyn A. Cunningham
David R. Diaz
Marc E. Duerden
John C. Ellis

Bernard J. Emkes
Bruce M. Goens
Paula A. Hall* (2020)
Susan K. Maisel* (2021)

Jon D. Marhenke
John P. McGoff* (2019)
Stephen W. Perkins
Richard H. Rhodes

John J. Wernert

DELEGATES

Delegates to the Annual State Convention

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Linda Feiwell Abels (2021)
Mary Pell Abernathy (2021)
Christopher D. Bojrab (2021)
Ann C. Collins (2020)
Carolyn A. Cunningham (2019)
Julie A. Daftari (2020)

Darrell D. Davidson (2021)
Marc E. Duerden (2020)
Robert S. Flint (2021)
Bruce M. Goens (2020)
Paula A. Hall (2020)
Ronda A. Hamaker (2019)

Mark M. Hamilton (2019)
C. William Hanke (2021)
Chad R. Kauffman (2020)
Jeffrey J. Kellams (2019)
Susan K. Maisel (2019)
Mary Ian McAteer (2020)

Ramana S. Moorthy (2020)
Thomas R. Mote (2021)
Mercy O. Obeime (2020)
Robert M. Pascuzzi (2020)
J. Scott Pittman (2019)
David M. Ratzman (2021)

Michael Rothbaum (2021)
Jodi L. Smith (2021)
Eric E. Tibesar (2020)
John J. Wernert (2020)
H. Jeffrey Whitaker (2020)
Steven L. Wise (2021)

ALTERNATE DELEGATES

Delegates to the Annual State Convention

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Ranai Abbasi (2021)
Jeffrey L. Amodeo (2021)
Nicholas M. Barbaro (2019)
Daniel J. Beckman (2019)
Brian D. Clarke (2020)
John H. Ditsler (2019)

Ann Marie Hake (2019)
Brian S. Hart (2020)
Tod C. Huntley (2019)
Kyle Jamison (2021)
David A. Josephson (2020)
Penny W. Kallmyer (2020)

Stephen R. Klapper (2019)
John E. Krol (2020)
David E. Lehman (2020)
David Mandelbaum (2019)
Christopher Mernitz (2021)
Martina F. Mutone (2021)

Ingrida I. Ozols (2021)
Stephen W. Perkins (2020)
Scott E. Phillips (2019)
Richard H. Rhodes (2020)
Dale A. Rouch (2019)
Amy D. Shapiro (2019)

Taha Shipchandler (2019)
Jason K. Sprunger (2019)
Richard M. Storm (2021)
Glenn A. Tuckman (2021)
*2 positions to fill, contact
EVP asap if interested.

INDIANA STATE MEDICAL ASSOCIATION

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John P. McGoff
2017-2018

Peter L. Winters
1997-1998

Jon D. Marhenke
2007-2008

William H. Beeson
1992-1993

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2000-2001

George H. Rawls
1989-1990

John D. MacDougall
1987-1988

George T. Lukemeyer
1983-1984

Alvin J. Haley
1980-1981

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Immediate Past President
John P. McGoff

At-Large
David R. Diaz

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Robert Flint (2020)



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